Every decision about care should be a decision about housing

NATIONAL HOUSING FEDERATION

“Housing associations are about far more than bricks and mortar. With strong local ties they deliver significant benefits to the wider local economy through specialised support and community investment services, as well as being major employers.

We have an important role to play in reaching those experiencing the sharpest health inequalities and saving the NHS significant amounts of money – they are a vital piece of the puzzle for integrated care.

Housing associations also provide three quarters of all rented supported and sheltered housing. Allowing people to choose to live at home can transform lives and help people to live independently and with dignity.”

Kate Henderson
Chief Executive
National Housing Federation

Read on to see examples of how housing associations are working in partnership to achieve positive health outcomes.

More than a roof over people's heads

Good quality, suitable and affordable housing is vital to a person's resilience, health and wellbeing. Housing that is properly adapted to suit the needs of residents, and having the right support in place, is key to keeping people out of hospital and living independently.

The government has emphasised the need for place-based joint working between clinical and public health bodies, local government, social care and the voluntary and community sectors and the integrated care systems was launched in July 2022. This shift towards proactive, preventative healthcare can promote physical and mental health outcomes and reduce health inequalities.

Housing, social care and health are already connected – as we saw during the pandemic – and housing associations are seeking greater collaboration.

Partnership working between the housing and health and social care sectors has never been more important, with social housing providers well placed to help relieve some of the tremendous pressure the NHS and social care are under.

How do housing associations reduce pressure on the NHS?

- Their early interventions help prevent disease from progressing and reduce the need for invasive and expensive interventions later on.
- By helping people to access the right services at the right time – reduce unnecessary GP and hospital visits and prevent people staying in hospital for longer than they need.
- Helping free up hospital beds and avoid delayed discharge of patients.
- By creating better join-up between primary, community and hospital services, meaning many illnesses can be managed in the community.
- Providing better integration between hospitals and social care, means more specialist support, so care home residents can be treated before they get unwell and avoid having to go to hospital.
- Sharing expertise about how to work with different populations and the challenges local people face so the NHS can make longer-term, targeted investment.
- Providing a link between healthcare and residents, to facilitate successful patient engagement.

A 2020 study found the average nine-minute GP appointment cost **£39.23**

"Ensuring there is holistic care that fits around people's needs includes ensuring that people receive the right care and support, and can maintain healthy independent living, beginning with where they live."

– Health Integration White Paper

Case Studies

Here are seven great examples of how housing and health are already working hand in hand, across the country.

1. whg

1/5

1/5 of the population in Walsall live in whg social homes.

56

years is the average healthy age expectancy in Walsall.*

97%

of whg homes are in the most disadvantaged areas of the borough.

34%

of those living in under-served communities are managing a long-term illness or disability.

As an anchor institution, one of our key aims is to promote health and prosperity, but we know that we cannot address deep-seated inequalities on our own. Over the last three years we have forged an excellent working relationship with our health partners. We are key stakeholders and committed partners on the Walsall Together Integrated Care Partnership and lead the Resilient Communities Health Prevention workstream.

We intervene with 'hard to reach' groups that rely heavily on the health system. Senior citizens, those who are lonely or isolated, and those managing chronic illness or disabilities can lack trust in institutions, meaning they get no support to live healthier lives - we offer a way for health partners to access these communities.

whg has two services funded by the NHS that are helping to target support where it is needed most:

- Kindness Champions, which works directly in communities tackling loneliness and isolation, and bringing people together to reduce the need for acute services further down the line.
- Diabetes Health Champions, specifically designed to tackle health inequalities in relation to diabetes outcomes. The team all have lived experience and are closely connected to the communities we serve. This recently launched, two-year service is already reaching into communities where diabetes levels are higher than the national figure.

*https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2018to2020

Over the past 12 months, whg's social prescribers have:

- Supported 277 people.
- Have reported a 90.8% positive change in their wellbeing.
- Reported that their low levels of wellbeing went from 87% to 28% after their intervention.
- Estimated thet they have a direct social value of £1.9m.
- Showed, in a review, that participants had reduced the number of times they had contacted their GP, nurse, or medical professional as a result of the support.

"Housing is given a seat at the table where health policy is made...our partners recognise the transformational role that housing can play in tackling wider determinants of health."

We're demonstrating to policymakers and programmes that people with the worst health outcomes are not hard to reach; it is the system that needs to refine its approach. Our relationship with our residents means we are able focus on prevention not treatment. Slowly but surely this is changing the way that the health system works with the local population.

2. Grand Union

Health is more than just the absence of disease; it is about people's overall wellbeing. Social, economic, and environmental factors all have direct impacts on health and housing associations have a responsibility to help create healthy thriving communities.

Natalie Blake works as a Health & Housing Coordinator at Grand Union to help preserve the link between health and housing. Advised and guided by a local Public Health team, she creates and develops projects to help improve community health.

"Encouraging people to take ownership and responsibility over their health is the best way to ensure sustainability of the work we do. We can signpost to specialists and make services more accessible to ensure everyone has an opportunity to improve their health."

- Natalie Blake

Targeted support

We use evidence from Grand Union's customer segmentation work, government statistics, local council health profiles and our own mapping software to build a picture as to who needs our help the most.

Fortnightly check-ins

We partnered with a local public health team and various organisations to provide regular and accessible healthcare information to over 100 people, including weight management, smoking cessation, mental health and drug and alcohol recovery. We also offer free 'Health MOT' checks, including blood pressure and BMI checks, and carbon dioxide tests on people interested in quitting smoking. This has led to a direct referral onto the stop smoking programme for someone who due to mobility issues needed this treatment delivered to their home.

Health resources

Access to information is a running theme through our projects. Natalie is creating health information resources on the Grand Union digital portal, as well as hard copies for those who need them. These resources contain all the local information about health services in their area.

3. Home Group

Improving local health outcomes involves many different stakeholders and skillsets. At Home Group, we are working to promote better care for residents, facilitate better community outreach and reduce the number of inappropriate or lengthy stays in inpatient settings.

We work with clinical experts and engage directly with residents to ensure they have a voice in developing new services.

Working with the Devon Partnership NHS Trust, we have introduced the Devon Enhanced Community Recovery Service. In five years, we've supported 37 people with mental health conditions, 30 of whom are now out of hospitals or acute wards and living back in the community.

Patient empowerment and independence is key. We can offer people safe, alternate opportunities to continue their care in an environment which feels more like home.

"Staff are really there for me. There is always someone available to talk to... I am more in control." – Home Group service user

Mental health hospital discharge service

Working with care providers in Durham and Darlington for the past 12 months, we have been supporting patients with housing and social care needs from admission right through to discharge into the community. Ensuring they have access to safe and secure housing prevents avoidable delayed discharge and removes pressures from ward-based settings.

So far Home Group has:

- Supported 212 people to find new accommodation.
- Helped 136 people to return home to live independently.
- Found a 76% improvement in users' mental wellbeing.
- Reduced the average hospital stay from 180 to 35 days – a potential saving per person for the NHS of £56,000.
- Provided 15 fully furnished properties to support those who may not have been suitable for mainstream housing or supported accommodation, providing an alternative route to discharge than a lengthy stay in an inpatient environment.

We care about providing a safe place to live and we use our rich experience supporting social care tenants to provide for the similar basic needs of people living in supported or inpatient environments.

4. Coastline Housing

Chi Winder is an essential community hub in Cornwall that provides crisis accommodation for people experiencing homelessness.

Services include:

- Health for Homeless Team: NHS doctors and nurses supporting those not registered with local GP services, in a fully equipped surgery room on our premises.
- Confidential space for discussions and drop-in clinics from the Health Vulnerability Liaison Service, who provide direct mental health support and direct referrals into mental health services.
- Street Vet: a drop-in clinic providing veterinary support to pets owned by people experiencing homelessness.
- Confidential access to We Are With You, a full needle exchange and shared care prescribing service. They work together with Coastline's qualified substance support coordinator on the Naloxone initiative, an evidence-based intervention that can block or reverse the effects of a heroin or opioid overdose. Since 2015, 102 residents and staff have been trained, saving 24 lives.
- Activities and Inclusion team, which provides opportunities for inclusion informed by the five ways to health and wellbeing – Connect, Be Active, Take Notice, Keep Learning and Give. The range of activities they provide include: gardening, cooking and exploring Cornwall through walking sessions.
- Regular, informal wellbeing sessions on a one-to-one basis with a person-centred approach or as group sessions, connecting people to groups and volunteering opportunities while taking time to listen to individuals and build confidence.

5. Thirteen Group

Thirteen has worked with a clinical commissioning group to host a two-bed facility at one of its extra care schemes since December 2016. This provides supported housing for up to six weeks for patients who are medically ready to be discharged from hospital but lack suitable accommodation to continue their recovery. It helps patients who need extra support, so they can regain their confidence to live more independently.

It also prevents delays in hospital discharges and allows for assessments to be carried out to understand the patient's future housing and care needs. The service also reduces pressure on local hospitals by providing additional capacity for those who need a little more support.

Sarah* was living independently until September 2022, when she was admitted to hospital. At the time, she was struggling with reduced mobility and had an infection which unfortunately caused her confusion.

When the time came for her to be discharged from hospital it was clear she needed extra support, so she could regain her confidence to live more independently. As it wasn't possible to arrange a support package in time for her discharge, she was offered a Step Up/Step Down bed at Orchid House.

This option worked well for Sarah as it meant she could be discharged from hospital with the care and support she needed while freeing up a hospital bed and providing savings to the NHS.

For each day
someone remains in hospital beyond the end of their treatment, it costs the NHS **£346**

Sarah has flourished during her time at Orchid House and feels reassured that staff are on hand 24/7. She also has a pendant fall alarm which has made her feel more confident to do the things she'd been worried about, like moving from a four-wheeled walking frame to crutches to support her mobility and independence, and has allowed her to come together with other people.

Sarah's time at Orchid House gave her time to evaluate her options, maintain her independence and make new friends.

*Name has been changed.

6. Greater Manchester Tripartite Agreement

"A safe, warm and secure home underpins people's ability to build a better quality of life, it improves general health outcomes and enables people to maintain independence. Housing...has a huge influence over mental health and well-being."

Better Homes, Better Neighbourhoods and Better Health is an agreement between Greater Manchester Combined Authority, Greater Manchester Housing Providers and Greater Manchester Health and Social Care Partnership. Launched in 2021, it commits the partners to prioritising good health in future decisions about planning, new homes and the support offered to those tenants in need to enable independent living.

The collaboration was built on existing joint housing and health projects, such as:

- A Bed Every Night – accommodation for people who sleep rough, which received significant NHS funding in order to improve physical and mental health.
- Housing First – hundreds of new homes and support for people who had been sleeping rough, or have complex needs, with the stability of their own home.
- Work to support mental health patients out of hospital to move into their own home, where they have been supported with their health needs, help to sustain their tenancies and to develop independence.
- Training of health and housing front line workers to identify and plan for people's health needs alongside their housing needs – particularly with vulnerable groups such as people who sleep rough, migrants or sex workers.

The agreement commits to:

- Working together to plan new housing and communities that enhance health by providing the right physical, social and green infrastructure.
- Ensuring people can access health, social care, work, education and training.
- Providing homes and support suitable for people with needs such as learning disabilities, living with dementia, mental health issues and physical disabilities.
- Retaining schemes such as A Bed Every Night, Social Impact Bond and Housing First.
- Involving housing providers more closely with local health teams.
- Ensuring that investment in housing also opens up new training and work opportunities, particularly for people who may need retraining or support, recognising that good work is good for mental health.

The Greater Manchester Housing Partnership (GMHP) is chaired by Charlie Norman, CEO of Moss Care St Vincent's, and is made up of 26 housing providers with 250,000 homes in the region.

7. West Yorkshire Partnership

The West Yorkshire Housing Partnership (WYHP) was formed in October 2020 and includes 11 housing associations providing social housing across West Yorkshire. Its prospectus includes health, care and homelessness as one of its five ambitions.

The West Yorkshire Mayor, Tracy Brabin set up a Dementia Taskforce chaired by Yvonne Castle, CEO of Johnnie Johnson Housing Association, demonstrating the crucial role housing associations can play in enabling health and wellbeing by delivering dementia-friendly housing and services for older people. The taskforce includes colleagues from the West Yorkshire combined authorities, the West Yorkshire local authorities, housing partners, the voluntary sector, the health sector and academia. WYHP and delivers dementia-friendly housing and services for older people.

"As a partnership, we're delighted to help take this important piece of work forward to look at the provision of dementia friendly housing and related services in West Yorkshire.

"We're working closely with housing, health and social care partners across the region and it's our aim to create a West Yorkshire wide dementia strategy. Having the right support and housing in place is vital because it can enable people with dementia to stay safe and to live independently for longer."

- Yvonne Castle, CEO of Johnnie Johnson and Chair of the Mayor's Dementia Taskforce.

"I'm proud of the progress we've made in bringing together the knowledge and expertise of local experts, including housing providers and care professionals."

- Tracy Brabin, Mayor of West Yorkshire.

We hope you have found these examples useful and can see more clearly what health and housing partnership working looks like across the country.

The new integrated care structure presents a key opportunity for working with local partnerships of housing associations, to help deliver your health and wellbeing objectives and embed real change.

Together we can mitigate ill health, promote healthier lifestyles and deliver significant efficiencies in public spending.

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